## COST RELATED REIMBURSEMENT OF ICF/MR FACILITIES

The New Mexico Title XIX Program makes reimbursement for appropriately licensed and certified Intermediate Care Facilities for the Mentally Retarded as outlined in this material.

I. GENERAL REIMBURSEMENT POLICY

The Human Services Department will reimbursement ICF/MR facilities the lower of the following, effective for services rendered on or after September 1, 1990:

A. Billed charges;

B. The prospective per diem rate as constrained by the ceilings (Section V) established by the Department as described in this plan.

II. DEFINITIONS

Accrual Basis of Accounting --Under the accrual basis of accounting, revenue is recorded in the period when it is earned, regardless of when it is collected. The expenditures for expense and asset items are recorded in the period in which they are incurred, regardless of when they are paid.

Cash Basis of Accounting --Under the cash basis of accounting, revenues are recognized only when cash is received and expenditures for expense and asset items are not recorded until cash is disbursed for them.

Governmental Institution --A provider of services owned and operated by a federal, state or local governmental agency.

Allocable Costs --An item or group of items of cost chargeable to one or more objects, precesses, or operations in accordance with cost responsibilities, benefits received, or other identifiable measure of application or consumption.

Applicable Credits --Those receipts or types of transactions which offset or reduce expense items that are allocable to cost centers as direct or indirect costs. Typical examples of such transactions are: purchase discounts, rebates, or allowances; recoveries or indemnities on losses; sales of scrap or incidental services; adjustments of over-payments or erroneous charges; and other income items which serve to reduce costs. If amounts are received from the Federal Government to finance hospital activities or service operations that are covered by the Medicaid program, then these amounts must be treated as applicable credits.

Charges --The regular rates established by the provider for services rendered to both Medicaid recipients and to other paying patients whether inpatient or outpatient. The rate billed to the Department shall be the usual and customary rate charged to all patients.

Cost Finding --A determination of the cost of services by the use of informal procedures, i.e., without employing the regular processes of cost accounting on a continous or formal basis. It is the determination of the cost of an operation by the allocation of direct costs and the proration of indirect costs.

Cost Center --A division, department, or subdivision thereof, a group of services or employees or both, or any other unit or type of activity into which functions of an institution are divided for purposes of cost assignment and allocations.

General Service Cost Centers --Those cost centers which are operated for the benefit of other general service areas as well as special or patient care departments. Examples of these are: housekeeping, laundry, dietary, operation of plant, maintenance of plant, etc. Costs incurred for these cost center are allocated to other cost centers on the basis of services rendered.

Special Service Cost Centers --Commonly referred to as Ancillary Cost Center. Such centers usually provide direct identifiable services to individual patients, and include departments such as the physical therapy and supply departments.

Inpatient Cost Centers --Cost centers established to accumulate costs applicable to providing routine and ancillary services to inpatients for the purposes of cost assignment and allocation.

RCC --This is the ratio of charges to charges. The bases or charges used in the RCC formula vary as to the costs to be allocated. The ratios may be expressed as follows:

1. ratio of recipient charges to total charges on a departmental basis.

2. ratio of recipient charges for ancillary services to total charges for ancillary services.

3. ratio of total patient charges by patient care center to the total charges of all patient care centers.

Provider --The entity responsible for the provision of services. The provider must have entered into a valid agreement with the Medicaid program for the provision of such services.

Facility --The actual physical structure in which services are provided.

Owner --The entity holding legal title to the facility.

## III. DETERMINATION OF ACTUAL, ALLOWABLE AND REASONABLE COSTS

### A. Adequate Cost Data

1. Providers receiving payment on the basis of reimbursable cost must provide adequate cost data based on financial and statistical records which can be verified by qualified auditors. The cost data must be based on an approved method of cost finding and on the accrual basis of accounting. However, where governmental institutions operate on a cash basis of accounting, cost data on this basis will be acceptable, subject to appropriate treatment of capital expenditures.

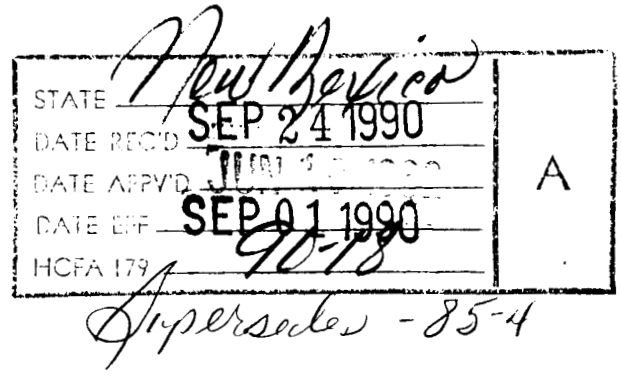
2. Cost finding-- the cost finding method to be used by ICF/MR providers will be the step-down method. This method recognizes that services rendered by certain non-revenue producing

departments or centers are utilized by certain other non-revenue producing centers. All cost of non-revenue producing centers are allocated to all centers which they serve, regardless of whether or not these centers produce revenue. The cost of the non-revenue producing center serving the greatest number of other centers, while receiving benefits from the least number of centers, is apportioned first. Following the apportionment of the cost of the non-revenue producing center, that center will be considered "closed" and no further costs will be apportioned to it. This applies even though it may have received some service from a center whose cost is apportioned later. Generally when two centers render services to an equal number, that center which has the greater amount of expense will be allocated first.

B. Reporting Year -- For the purpose of determining a prospective per diem rate related to cost for ICF/MR services, the reporting year is the provider's fiscal year. The provider will submit a cost report each year.

C. Cost Reporting -- At the end of each fiscal year the provider will provide to the state agency or its audit agent an itemized list of allowable cost (financial and statistical report) on the N.M. Title XIX cost reporting form. This itemized list must be submitted within 90 days after the close of the provider's cost reporting year. Failure to file a report within the 90 day limit, unless an extension is granted prior to the due date, will result in suspension of Title XIX payments. Extensions must be requested in writing from the Medical Assistance Division prior to the due date of the cost report.

In the case of a change of ownership, the previous provider must file a final cost report as of the date of the change of ownership in accordance with reporting requirements specified in this plan. The Department will withhold the last month's payment to the previous provider as security against any outstanding obligations to the Department. The provider must notify the Department 60 days prior to any change of ownership.




D. Retention of Records

1. Each ICF/MR provider shall maintain financial and statistical records of the period covered by such cost report for a period of not less than four years following the date of submittal of the N.M. Title XIX Cost Report to the state agency. These records must be accurate and in sufficient detail to substantiate the cost data reported. The provider shall make such records available upon demand to representatives of the State Agency, the State Audit Agent, or the Department of Health and Human Services.

2. The State Agency or its audit agent will retain all cost reports submitted by providers for a period of not less than three years following the date of final settlement of such report.

E. Audits

Audits will be performed in accordance with 42 CFR 447.202.

Desk Audit Each cost report submitted will be subjected to a comprehensive desk audit by the state audit agent. This desk audit is for the purpose of analyzing the cost report. After each desk audit is performed, the audit agent will submit a complete report of the desk review to the State Agency.

Field Audit Field audits will be performed on all providers at least once every three years. The purpose of the field audit of the provider's financial and statistical records is to verify that the data submitted on the cost report are in fact accurate, complete and reasonable. The field audits are conducted in accordance with generally accepted auditing standards and of sufficient scope to determine that only proper items of cost applicable to the service furnished were included in the provider's calculation of its cost and to determine whether the expenses attributable to such proper items of cost were accurately determined and reasonable.

After each field audit is performed, the audit agent will submit a complete report of the audit to the

syringes, catheters, ileostomy, and colostomy supplies).

(4) Use of equipment and facilities

(5) General services, including administration of oxygen and related medications, hand feeding, incontinency care, tray service and enemas.

(6) Items furnished routinely and relatively uniform to all patients, such as patient gowns, water pitchers, basins and bed pans.

(7) Items stocked at nursing stations or on the floor in gross supply and distributed or used individually in small quantities, such as alcohol and body rubs, applicators, cotton balls, bandaids, laxatives and fecal softeners, aspirin, antacids, OTC ointments, and tongue depressors.

(8) Items which are used by individual patients but which are reusable and expected to be available, such as ice bags, bed rails, canes, crutches, walkers, wheelchairs, traction equipment, oxygen administration equipment, and other durable equipment.

(9) Special dietary supplements used for tube feeding or oral feeding even if prescribed by a physician.

(10) Laundry services other than for personal clothing.

(11) Oxygen for emergency use--The Department will allow two options for the purchase of oxygen for patients for whom the attending physician prescribes oxygen administration on a regular or on-going basis:

a) The provider may purchase the oxygen and include it as a reimbursable cost in its cost report. This is the same as the method of reimbursement for oxygen administration equipment; or

b) The Department will make payment directly to the medical equipment provider in accordance with procedures outlined in Medical Assistance Manual Section 310.08, Medical Supplies, and subject to the limitations on rental payments contained in that section.

(12) All services delivered in relation to active treatment, such as physical therapy, occupational therapy, speech therapy, psychology services, recreational therapy, etc.

(13) Managerial, administrative, professional and other services related to the providers operation and rendered in connection with patient care.

b. Facility cost, for the purpose of specific limitations included in this plan, include only depreciation, lease costs, and long term interest.

(1) Depreciation is the systematic distribution of the cost or other basis of tangible assets, less salvage value, over the estimated life of the assets.

a) The basis for depreciation is the historical cost of purchased assets or the fair market value at the time of donation for donated assets.

b) Historical cost is the actual

cost incurred in acquiring and preparing an asset for use.

c) Fair market value is the price for which an asset would have been purchased on the date of acquisition in an arms-length transaction between an informed buyer and seller, neither being under any compulsion to buy or sell. Fair market value shall be determined by a qualified appraiser who is a registered member of the American Institute of Real Estate Appraisers (MAI) and who is acceptable to the Department.

d) In determining the historical cost of assets where an on-going facility is purchased, the provisions of Medicare Provider Reimbursement Manual (HIM-15) will apply.

e) Depreciation will be calculated using the straight-line method and estimated useful lives approximating the guidelines published in American Hospital Association Chart of Accounts for Hospitals.

(2) Long-term interest is the cost incurred for the use of borrowed funds for capital purposes, such as the acquisition of facility, equipment, improvements, etc., where the original term of the loan is more than one year.

(3) Lease term will be considered a minimum of five years for purposes of determining allowable lease costs.

c. Gains and Losses on Disposition

Gains or losses on the disposition of depreciable assets used in the program are calculated in accordance with the HIM-15. Disposition of a provider's depreciable assets which effectively terminates its participation in the program shall include the sale, lease, or other disposition of a facility to another entity whether or not that entity becomes a participant in the program. The amount of gain on the disposition of depreciable assets will be subject to recapture as allowed by HIM-15.

d. Depreciation, interest, lease cost, or other costs are subject to limitations stated in the HIM-15.

e. Facility costs are subject to all other terms stated in HIM-15 that are not modified by these regulations.

H. Non-Allowable Costs

1. Bad debts, charity, and courtesy allowances: bad debts on non-Title XIX program patients and charity and courtesy allowances shall not be included in allowable costs.

2. Purchases from related organizations: cost applicable to services, facilities, and supplies furnished to a provider by organizations related to the provider by common ownership or control shall not exceed the lower of the cost to the related organization or the price of comparable services, facilities or supplies purchased elsewhere. Providers shall identify such related organizations and costs in the States's cost reports.

3. Return on equity capital.

4. Other cost and expense items identified as unallowable in HIM-15.

5. Interest paid on overpayments as per Medical Assistance Manual Section 307.

6. Any civil monetary penalties levied in connection with licensure, certification, or fraud regulations.

IV. ESTABLISHMENT OF PROSPECTIVE PER DIEM RATES

Prospective per diem rates will be established as follows and will be the lower of the amount calculated using the following formulas, or any applicable ceiling:

A. Base Year

For implementation Year 1 (effective September 1, 1990), the providers base year will be for cost reports filed for base year periods ending no later than June 30, 1990. Since these cost reports will not be audited at the time of implementation, an interim rate will be calculated and once the audited cost report is settled, a final prospective rate will be determined. Retrospective settlements of over or under payments resulting from the use of the interim rate will be made.

Rebasing of the prospective per diem rate will take place every three years. Therefore, the operating years under this plan will be known as Year 1, Year 2, and Year 3. Since rebasing is done every three years, operating year 4 will again become Year 1, etc.

Costs incurred, reported, audited and/or desk reviewed for the provider's last fiscal year which ends in the calendar year prior to year 1 will be used to re-base the prospective per diem rate. Rebasing costs in excess of 110% of the previous year's reported cost per diem times the index (as described further on in these regulations) will not be recognized for calculation of the base year costs.